State of California
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

FINAL STATEMENT OF REASONS
Subject Matter:
Workers' Compensation Information System

Title 8, California Code of Regulations, sections 9701 through 9703

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 133, 138.6, and 138.7, has adopted Article 1.1, Subchapter 1 to Chapter 4.5 of Title 8, California Code of Regulations, commencing with section 9701, relating to the Workers' Compensation Information System.

Section 9701	Definitions
Section 9702	Electronic Data Reporting
Section 9703	Access to Individually Identifiable Information

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

As authorized by Government Code §11346.9(d), the Administrative Director incorporates the Initial Statement of Reasons prepared in this matter. California Civil Code section 1798.24, which requires specific procedures when the researcher is the University of California or a non profit educational institution, was amended effective January 1, 2006. Regulation section 9703 has been amended to reflect the change in the statute.

The proposed regulation changes are summarized below.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (December 16, 2005 through January 5, 2005.)

Modifications to Section 9701 Definitions

Subdivisions (b) and (c): The dates for the "California EDI Implementation Guide for First and Subsequent Reports of Injury" and "California EDI Implementation Guide for Medical Bill Payment Records" have been changed to December 2005 as changes have been made to the June and July drafts. "Excerpted" has been changed to "and excerpts" in (c) to improve the sentence syntax.

Subdivision (e) has been amended to include California Insurance Guarantee Association (CIGA) in the definition of claims administrators. This will clarify that in cases where CIGA does not have a third party administrator, CIGA is required to report to the WCIS.

Subdivision (f) defining "Claims Administrator's Agent" has been added to define the term which is now used in section 9702(a)(1). The term is defined as "Any entity contracted by the claims administrator to assist in adjusting the claim(s) including third party administrators, bill reviewers, utilization review vendors, and electronic data interchange vendors." Claims administrators contract with other agencies that may have access to data elements that are required to be reported to the WCIS. By defining this term, the regulations will be clear with regard to the requirement to report data elements known to both the claims administrator and the claims administrator's agents. The subdivisions following (f) have been re-lettered.

Subdivision (l) has been corrected to refer to section 5 instead of 6 of the IAIABC EDI Implementation Guide for Medical Bill Payment Records.

Modifications to Section 9702 Electronic Data Reporting

Subdivision (a)(1) was added to allow for a partial or total variance with regard to the requirement to report the medical data elements. The subdivision allows a claims administrator to make a written request for a six month partial variance because it is unable to transmit some of the data or some of the data is unavailable to the claims administrator. Alternatively, a claims administrator may also make a written request for a twelve month total variance if it can show that compliance with the reporting deadlines set forth in subdivision (e) would cause undue hardship to the claims administrator; that the claims administrator is has not contracted with a bill review company to review medical bills submitted by providers in its workers' compensation claims; and that the claims administrator is unable to transmit medical data to public or private research or statistical entities. The claims administrator must also submit a plan, documenting the means by which the claims administrator will ensure full compliance with the data reporting within twelve months from the request. The variance subdivision was added to address comments and concerns that some claims administrators may not have all of the data required or may not have the ability to comply with subdivision (e) within six months of the effective date.

The chart in subdivision (b) was rearranged so that the data element names are listed alphabetically, which should make it easier for the claims adjusters to use the chart. Data element "Industry Code – DN 25" was added to the chart

The chart in subdivision (c) was rearranged so that the data element names are listed alphabetically, which should make it easier for the claims adjusters to use the chart.

The chart in subdivision (d) was rearranged so that the data element names are listed alphabetically, which should make it easier for the claims adjusters to use the chart. In addition, data element 144 (Current date disability began) was eliminated as it is not an IAIABC EDI Release 1 data element. The words "and stipulated settlements" were added to footnote 2 for clarity. The "Note" at then end of the chart was deleted, as that language applies to all of the charts and is now subdivision (h).

The June 1, 2006 dates in the first paragraph of subdivision (e) and in (i)(3) were change to allow OAL to insert a date six months after the regulations are filed with the secretary of state. This will ensure the claims administrators have a six month lead time to comply with subdivision (e). The last sentence of the paragraph was correct to refer to the California EDI Implementation

Guide for Medical Bill Payment Records instead of the First and Subsequent Reports of Injury.

In the chart for subdivision (e), two data elements were added: ICD-9 CM Principal Procedure Guide Code (525) and ICD-9 CM Procedure Code (736). Footnotes (5) and (8) were deleted because the information is not needed. Footnote (2) was deleted because if the claims administrator does not have the required information, it may request a variance. The remaining footnotes were renumbered. The reference to "Health Care Financing Administration ("HCFA") in footnote 10 was changed to the "Centers for Medicare & Medical Services ("CMS")" as that is the correct name of the entity.

Because the "Note" became subdivision (h), the remaining subdivisions were re-lettered.

Modifications to Section 9703 Access to Individually Identifiable Information

In subdivision (d) the unnecessary word "agencies" was deleted and the acronym "CHSWC" was added. In subdivisions (d)(1)-(5) the word "commission" was replaced with "CHSWC" for clarity. In subdivision (d)(2) and (f) reference was made to Civil Code section 1789.24 which requires specific procedure when the researcher is the University of California or a non profit educational institution. This Civil Code section became effective on January 1, 2006. The Civil Code section was also added to the references.

Modifications to "California EDI Implementation Guide for First and Subsequent Reports of Injury"

Modifications made to the "California EDI Implementation Guide for Medical Bill Payment Records," which was re-dated to reflect the December changes, are listed on the errata sheet contained with the Guide and listed here:

ERRATA

1. The Social Security Number (DN 42) is now a Mandatory/Serious data element (changed section L, FROI data requirements table, C/M --> M/S).

2. The Industry Code (DN 25) has been added as a Conditional/Serious FROI data element (added DN 25 to section E, pg E-7, list of FROI data elements, added DN 25 to section L, FROI data requirements table and added footnote, "**DN42: if the Claims Administrator does not know the SSN, the resulting TE error code can be ignored.").

3. The Current Date Disability Began (DN 144) has been removed from the SROI data element list in E-9 of section E.

4. B-2 and B-3 of Appendix B has been updated to show the latest changes to section E and L of the guide.

5. The footer dates, TOC and first page dates have been updated to December 2005.

6. Section E in the TOC has been updated to "Legal Authorities" to match the title of section E.

7. The FROI UR data requirements have been removed from section L, FROI data requirements table.

Modifications to "California EDI Implementation Guide for Medical Bill Payment Records"

Modifications made to the "California EDI Implementation Guide for Medical Bill Payment Records," which was re-dated to reflect the December changes, are listed on the errata sheet contained with the Guide and listed here:

ERRATA

1. Added error codes 100_Mandatory Element Missing and 300_Mandatory Segment to the 997 Functional Acknowledgement Error Codes (page 38). (This change will streamline the reporting procedure.)

2. Dropped error codes 125_ Element Delimiter, 210_ Incorrect Component Format, 215_ Incorrect Component Length, 220_ Component Delimiter, 310_ Invalid Start End, 320_ Segment Terminator, 410_ Invalid Control Number, and 430_ Unknown Version from the 997 Functional Acknowledgement Error Codes (page 38). (This change will streamline the reporting procedure.)

3. The DWC\WCIS has developed a several Medical Bill Payment scenarios for California including Medical Provider Networks and reevaluations to be included in the batch of test files (page 36). (This new sentence clarifies the testing procedures.)

4. The DWC\WCIS Medical Bill Payment Medical Provider Networks and reevaluations as well as other specific scenarios will be tested for validity and accuracy (page 42). (This new sentence clarifies the testing procedures.)

5. Segment BGN to BHT on page 50. (This corrects a typographical error.)

6. Segment MN1 to NM1 on pages 50, 52, and 54. (This corrects a typographical error.)

7. Segment TP to DTP on page 51. (This corrects a typographical error.)

8. "BR" to "E or R" p39. (This corrects a typographical error.)

9. "BA" to "A" p39. (This corrects a typographical error.)

10. Loop 2010C to loop 2000C on p39. (This corrects a typographical error.)

11. "If DN 502, value is "RX" or "MO" DN571 DRUGS/SUPPLIES NUMBER OF DAYS, page 77. (This change is made in response to a comment from a pharmaceutical company. The change clarifies the trigger for reporting.)

12. "If DN 502, value is "RX" or "MO" DN570 DRUGS/SUPPLIES QUANTITY DISPENSED, page 77. (This change is made in response to a comment from a pharmaceutical company. The change clarifies the trigger for reporting.)

13. "If DN 502, value is "RX" or "MO" DN572 DRUGS/SUPPLIES BILLED AMOUNT, page 77. (This change is made in response to a comment from a pharmaceutical company. The change clarifies the trigger for reporting.)

14. Changed from "M" to "C" with a mandatory trigger. (This change is made in response to a comment from a pharmaceutical company. The change clarifies the trigger for reporting. The below table is found in section L and is the data Element Required Table.)

557	Diagnosis Pointer	~~M~~ C	O	O	If DN503 equals "B" and DN714 or DN715 is present
714	HCPCS Line Procedure Billed Code	~~M~~ C	O	O	If different then DN715
522	ICD_9 CM Diagnosis code	~~M~~ C	O	O	If DN502 not equal MO or RX
715	Jurisdictional procedure billed code	~~M~~ C	O	O	If procedure is included in the California OMFS
729	Jurisdictional procedure paid code	~~M~~ C	O	O	If different than DN715
524	Procedure Date	~~M~~ C	O	O	If DN 503 equals "A" and a surgical procedure was preformed
552	Total charge per line other	~~M~~ C	O	O	If DN502 not equal MO or RX
542	BILLING PROVIDER POSTAL CODE	C	O	O	If different than DN656
630	BILLING PROVIDER STATE LICENSE NUMBER	C	O	O	If different than DN643(see WCIS regulations)

15. Change the wording on DN737 HCPCS Bill Procedure code "if DN626 Principle diagnosis is present" to "and more than one procedure preformed." (This is a clarification regarding when to report the data element made in response to comments. The change is made to the Data Element Required Table.)

16. Added Loop 2000B, segment HL on page 50. (IAIABC requirement) (This change is necessary to meet the technical IAIABC requirements.)

17. Added Loop 2010BA, segment MN1 on page 50. (IAIABC requirement) (This change is necessary to meet the technical IAIABC requirements.)

18. Remove all FEIN edits (629, 187, 679, 6, 704, 642, 586,) pp. 87-88. (This change simplifies the reporting process.)

19. Remove error code 040 from DN42 Employee Social Security Number on page 84. (This change is necessary because some employees do not have Social Security Numbers.)

20. Removed all name edits (528, 188, 563, 44, 43, 45, 678, 7, 209, 638, 589) on page 89. (This change simplifies the reporting process.)

21. Added two data elements, DN525 ICD-9 CM Principle Procedure Code and DN736 ICD_9 CM Procedure Code to tables on pages 51, 72, 80, 84. (This change was made in

response to comments. It allows the trading partner to report the proper codes for hospital providers.)

22. Changed Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS), page 99. (This corrects the name which has been changed.)

23. Deleted reference to Health Care Financing Administration (HCFA), page 100. (This change is necessary because the name has been changed.)

24. Deleted Blue Cross and Washington publishing Company on page 116. (This clarifies the data source.)

25. Changed DN729 from mandatory to conditional with trigger "If different then DN715" (This change will streamline the reporting procedure.)

26. Deleted error code 056, 062 and 118 (page 42 detailed error messages). (This change will streamline the reporting procedure.)

27. Rewrote section I. (This section was updated in response to comment from Intracorp to reflect the Information System structural changes. The revisions include the current procedures and revised protocols to transmit files and data between the DWC and the trading partners.)

28. Rewrote section N. (In response to comment from Intracorp, the revisions add clarification for the trading partners about when and how to send data and the procedures for processing data.)

29. Rewrote section G. (In response to comment from CWCI regarding BETA testing, the revisions update and streamline the testing procedures and structural files.)

30. Changed the wording of the mandatory trigger in response to oral comment from Ingenix, ROES and other trading partners during the public comment period. The comments are related to the corrections to data requirements contained in the IAIABC 837 electronic transmission.

718	JURISDICTIONAL MODIFIER BILLED CODE	C	O	O	If DN715 is modified
518	DRG CODE	C	O	O	If DN 503 equals "A" and if included in the California Inpatient Hospital Fee Schedule
550	PRINCIPAL PROCEDURE DATE	C	O	O	If DN 503 equals "A" and if DN525 or DN626 is present
535	ADMITTING DIAGNOSIS CODE	C	O	O	If Billing Format Code, DN 503, is "A" and patient has been admitted
576	REVENUE PAID CODE	C	O	O	If different than DN559
570	DRUGS/SUPPLIES QUANTITY DISPENSED	C	O	O	If DN 502, value is "RX" or "MO".
571	DRUGS/SUPPLIES NUMBER OF DAYS	C	O	O	If DN 502, value is "RX" or "MO".

572	DRUGS/SUPPLIES BILLED AMOUNT	C	O	O	If DN 502, value is "RX" or "MO".
579	DRUGS/SUPPLIES DISPENSING FEE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
562	DISPENSE AS WRITTEN CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
564	BASIS OF COST DETERMINATION CODE	C	O	O	If a pharmacy bill submitted on universal claim form/NCPDP format
721	NDC BILLED CODE	C	O	O	If a pharmaceutical bill or a drug is dispensed by a physician during an office visit.
527	PRESCRIPTION BILL DATE	C	O	O	If different than DN604
649	RENDERING BILL PROVIDER SPECIALTY LICENSE NUMBER	C	O	O	If different then DN643
592	RENDERING LINE PROVIDER NATIONAL ID	C	O	O	When available (see WCIS regulations)
599	RENDERING LINE PROVIDER STATE LICENSE NUMBER	C	O	O	If different from DN 643
509	SERVICE BILL DATE(S) RANGE	C	O	O	If different than DN605
516	TOTAL AMOUNT PAID PER BILL	C	O	O	If different than DN501
522	ICD-9 CM DIAGNOSIS CODE	C	O	O	If DN521 is present and more then one diagnosis occurs or if DN503 = B and DN714 or DN715 or a drug is dispensed by a physician during an office visit.
567	DME BILLING FREQUENCY CODE	C	O	O	If DN502 = DM and DN565 is present
565	TOTAL CHARGE PER LINE – RENTAL	C	O	O	If Durable Medical Equipment is rented
566	TOTAL CHARGE PER LINE – PURCHASE	C	O	O	If Durable Medical Equipment is purchased
554	DAYS/UNITS BILLED	C	O	O	If DN715 or DN714 are present or DN502 = DM, or a drug is dispensed by a physician during an office visit.
553	DAYS/UNITS CODE	C	O	O	If DN715 or DN714 are present or DN502 = DM or a drug is dispensed by a physician during an office visit.
605	SERVICE LINE DATE(S) RANGE	C	O	O	If not a pharmacy bill submitted on universal claim form/NCPDP format
525	ICD-9 CM PRINCIPAL PROCEDURE CODE	C	O	O	If Billing Format Code, DN 503, is "A" and the code value is not a HCPCS code. For surgical bills only.
736	ICD_9 CM PROCEDURE CODE				If DN525 is present and more than one procedure is preformed
737	HCPCS BILL PROCEDURE CODE	C	O	O	If DN626 is present and more than one procedure is preformed

31. Added a paragraph, page 25. This change is made in response to comment from Intracorp requesting clarification.

32. Added a reference to California Department of Consumer Affairs, page 116. This change is made in response numerous comments regarding the availability of state license numbers. (CWCI, Intracorp, PMSI).

THE FOLLOWING NON-SUBSTANTIVE / CORRECTIONS WITHOUT REGULATORY EFFECT WERE MADE TO THE TEXT OF THE REGULATIONS AFTER THE CLOSE OF THE FINAL COMMENT PERIOD

Modifications to Section 9701 Definitions

In subdivision (b),the date of December 2005 was changed to February 2006 to reflect the most recent version with the non substantive revisions.

In subdivision (l), the reference to the IAIABC section 14 was corrected to refer to section 11.

Modifications to Section 9703 Access To Individually Identifiable Information

The typographical error in the reference to Civil Code section 1798.24(t) in subdivision (d)(2) was corrected.

Modifications to "California EDI Implementation Guide for First and Subsequent Reports of Injury"

Nonsubstantive changes made to the "California EDI Implementation Guide for Medical Bill Payment Records," which was re-dated to reflect the February changes, are listed on the errata sheet contained with the Guide and listed here:

ERRATA

1) The Social Security Number (DN 42) is now a Mandatory/Serious data element (changed section L, FROI data requirements table, C/M → M/S) and added footnote, "**DN42: if the Claims Administrator does not know the SSN, the resulting TE error code can be ignored.").

2) The Industry Code (DN 25) has been added as a Conditional/Serious FROI data element (added DN 25 to section E, pg E-7, list of FROI data elements, added DN 25 to section L, FROI data requirements table.

3) The Current Date Disability Began (DN 144) has been removed from the SROI data element list in E-9 of section E.

4) B-2 and B-3 of Appendix B has been updated to show the latest changes to section E and L of the guide.

5) The acknowledgements in the introduction have been updated.

6) The footer dates, TOC and title page dates have been updated to February, 2006.

7) Labor Code sections 138.6 and 138.7 have been updated in Section D.

8) The WCIS regulations have been updated in Section E.

9) Section E in the TOC has been updated to "Legal Authorities" to match the title of section E.

10) The FROI UR data requirements have been removed from section L, FROI data requirements table.

11) The Trading Partner contact information has been updated in sections B and G.

12) New EDI vendors have been added to section J.

Modifications to "California EDI Implementation Guide for Medical Bill Payment Records"

Nonsubstantive changes made to the "California EDI Implementation Guide for Medical Bill Payment Records," are listed on the errata sheet contained with the Guide and listed here:

ERRATA

1. Replaced the words "claims administrators (insurers, self-administered self-insured employers, and third party administrators)" with "trading partners, i.e. senders," on page 5 for clarification in response to Intracorp and CWCI comments.

2. Corrected LC 138.6 and LC 138.7 on pages 20-22 with current versions for clarification in response to comment from CWCI.

3. Corrected typographical error "100–330" to "1-9" on page 37 in response to comment from Intracorp.

4. Corrected typographical error "MN1" to "NM1" on page 49 in response to comment from Intracorp.

5. Inserted "Segment LM Code Source Information" on page 55 for clarification in response to comment from Intracorp.

6. Inserted footnote "Adjustments to DN501, DN552, DN565, DN566, or DN572 in accordance with the California Official Medical Fee Schedule, the California Inpatient Hospital Fee Schedule, or any other Official DWC Fee Schedule (pharmaceuticals etc.) can use Bill\Service Adjustment Group Code = "MA" and Bill\Service Adjustment Reason Code = '45" for medical bill payment record reporting purposes to the DWC\WCIS" on page 80 in response to oral comment during the California DWC EDI Task Force during regular weekly meetings to clarification of medical data reporting requirements.

7. Corrected typographical error "Bill" to "Billed" on pages 104 -115 in response to comment from State Compensation Insurance Fund.

UPDATE OF MATERIAL RELIED UPON / DOCUMENTS ADDED TO RULEMAKING FILE

In addition to the documents identified in the Initial Statement of Reasons the following documents were relied upon by the Division and were made available to the public as required by Government Code Section 11347.1.

Title of Document Added to Rulemaking File	Dates of Availability for Public Comment
Comments received by the Division of Workers' Compensation concerning the Division's proposed changes.	October 7, 2005 through November 22, 2005 December 16, 2005 through January 5, 2006
Opinion and Order of WCAB re: *California Insurance Guarantee Association for Approval of its Medical Network Plan v. Division of Workers' Compensation* (April 26, 2005) WCAB Case no. Misc. #249	

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed amendments do not apply to any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts.

The public comment period was as follows:

Initial 45-day comment period on proposed regulations:

October 7, 2005 through November 22, 2005

First 15-day comment period on modifications to proposed text:

December 16, 2005 through January 5, 2006